CHIEF OF NAVAL OPERATIONS

SAFETY AND OCCUPATIONAL HEALTH BRANCH
(N454)

REPORT

ON THE

U.S. NAVY OCCUPATIONAL SAFETY AND HEALTH PROGRAM

COVERING

FISCAL YEAR 1996

Agency Annual Report
Occupational Safety and Health Program

FISCAL YEAR 1996

Name of Agency	**Department of the Navy**
Name of Component	**U.S. Navy**
Address	**The Pentagon** **Washington, D.C. 20350-2000**
Number of Employees covered by this report	**210,583 (Civilian Average)**
Number of Activities covered by this report	**900 (Approximate)**
Name of individual responsible for the occupational safety and health program of the agency or component covered by this report	**VADM W. J. HANCOCK, USN**
Telephone number of this individual	**(703) 697-3014**
Title of this individual	**Deputy Chief of Naval Operations (Logistics) (N4)**
Point of contact for this report	**Clint Maish, N454C**

U.S. NAVY
OCCUPATIONAL SAFETY AND HEALTH PROGRAM REPORT
FOR FISCAL YEAR 1996

I. *REPORT COVERAGE*. The statistical aspect of this report covers only the shore installations of the U.S. Navy and its civilian employees. However, significant afloat initiatives are highlighted throughout the report and in Section IV. The average number of United States citizens employed by the U.S. Navy during fiscal year 1996 was 210,583. The U. S. Navy also employed approximately 2000 part-time and 10,500 temporary employees. These employees worked at approximately 900 "activities" or installations. The U.S. Navy has activities and offices located throughout the world employing U.S. civilians. All types and forms of operations, processes, work environments and occupations exist within the Navy. We are a major national industrial employer with over 28,000 civilian employees at naval shipyards, 13,000 at aviation repair activities, and 12,500 at public works/construction activities. Our blue collar/wage grade workforce is approximately 48,000.

II. *PROGRAM PERFORMANCE*.

1. INJURY AND ILLNESS CASE EXPERIENCE.

a. FEDERAL EMPLOYEES INJURY COMPENSATION INJURY/ILLNESS STATISTICS. Table 1 below provides a summary of our injury compensation claims experience between fiscal year (FY) 1992 and FY 1996. The case data in the Table was obtained from Office of Workers' Compensation Programs (OWCP) Federal Employees Compensation Act (FECA) Reports. Our total claims experience declined 35 per cent from the level in FY 1992 and our total case rate declined 12.5 percent. We also reduced the number of lost time cases by 37 percent between FY 1992 and FY 1996, and our lost time case frequency rate by 15.4 percent. Chart 1 on the next page

Table 1: OWCP INJURY AND ILLNESS CASES

Category	FY 92	FY 93	FY 94	FY 95	FY 96
Total Injury/Illness Cases*	17663	16980	15948	13788	11507
Fatalities**	4	1	4	3	2
Lost Time Cases	9950	9741	8955	7526	6270
Number of Employees***	282751	266512	247707	228726	210583

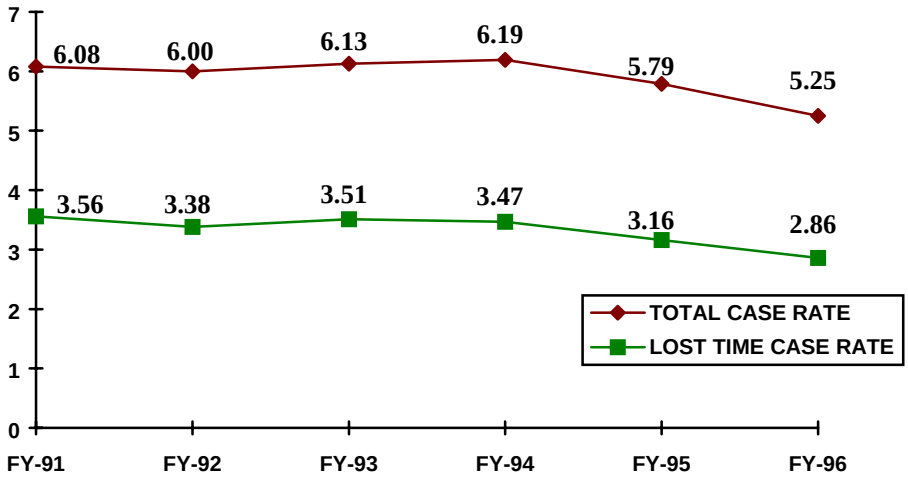
OWCP RATES OF INJURIES AND ILLNESSES PER 100 EMPLOYEES

Category	FY 92	FY 93	FY 94	FY 95	FY 96
OWCP Total Case Rate	6.00	6.13	6.19	5.79	5.25
OWCP Lost Time Case Rate	3.38	3.51	3.47	3.16	2.86

Source of Data: * 0WCP FECA TABLE #2 DATA (Cases filed during FY)
**** NAVAL SAFETY CENTER OCCUPATIONAL INJURY DATA BASE**
***** NAVY CIVILIAN PERSONNEL DATA SYSTEM (NCPDS)**

graphically shows our injury/illness claims performance in terms of total case rates and lost time case rates for the last six years. FY 1996 is our best year on record in terms of reducing total case numbers and frequency rates. Chart 2 provides a breakdown of total cases by nature on injury for the last two fiscal years.

OWCP INJURY AND ILLNESS CASES



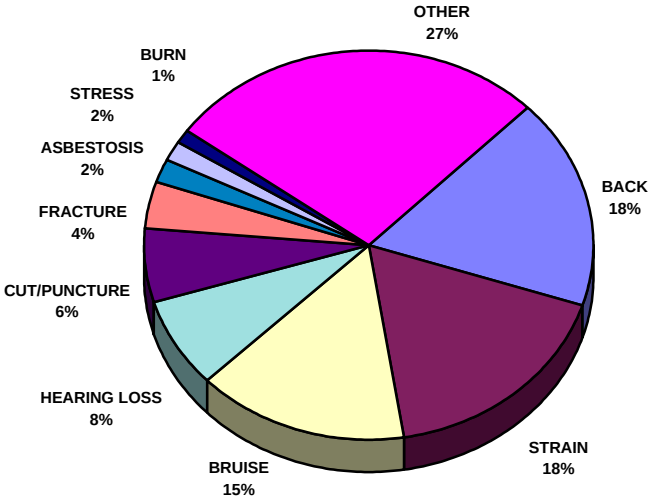
Total Case Rate declined 14% between FY-91 and FY-96;
the Lost Time Case Rate declined 20%.

CHART 1

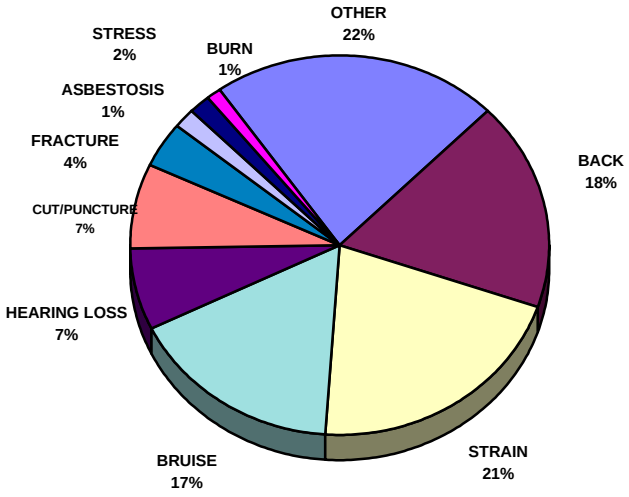
(1) **INJURY COMPENSATION COSTS**. As shown graphically in Chart 3, in compensation billing year (CBY) 1996, FECA costs rose very little, and certainly well below medical cost inflation levels. This cost containment is considered to be a result of past mishap prevention efforts which substantially reduced the number of new cases filed each year between the middle 1980's and the early 1990's. As you can see in the Chart 3, our overall medical claims numbers have also steadily declined, reducing approximately 23 per cent since CBY 1991. Analysis of our medical case billing in CBY 1996 reveals that nearly 70% of the charges were for cases prior to 1990 with less than 1% of the charges for 1996 cases. In terms of case numbers, 41% of the cases billed were for injuries prior to 1990, and almost 50% before 1993. Only 7.4% of the cases actually occurred in 1996. Since back injuries are the most frequently encountered type of injury in the U.S. Navy, we have included Charts 4 and 5 to provide data on back injury cases and costs. These charts reveal our achievement in reducing both the number and costs of these injuries in recent years.

The injury compensation cost per case increased 12.4 % in 1996 over 1995, and has increased 48.4 % since 1991. The data supports the significance of our cost containment achievements since our total 1996 costs increased only 0.0009 % over 1995 and 14.7 % since 1991.

NATURE OF INJURY
FECA CASES DURING FISCAL YEAR



FY 1996



FY 1995

Source: OWCP FECA Data

CHART 2

FECA CHARGEBACK DATA BY BILLING YEAR

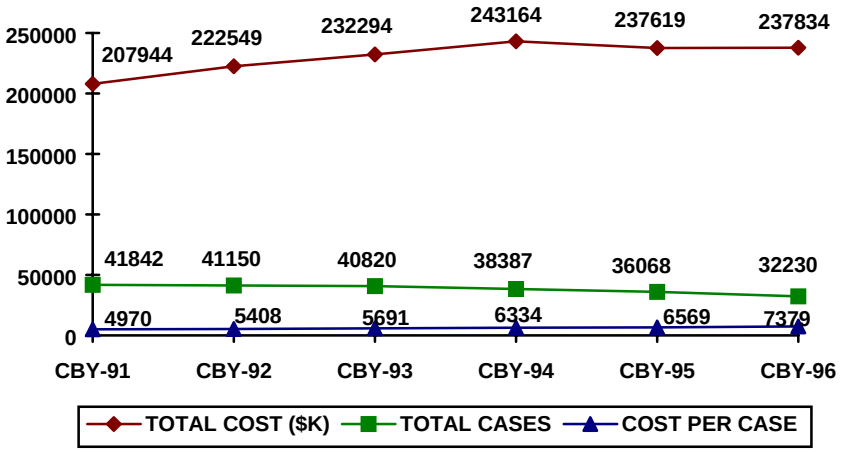


CHART 3

NAVY BACK INJURIES
FECA BILLING CASES

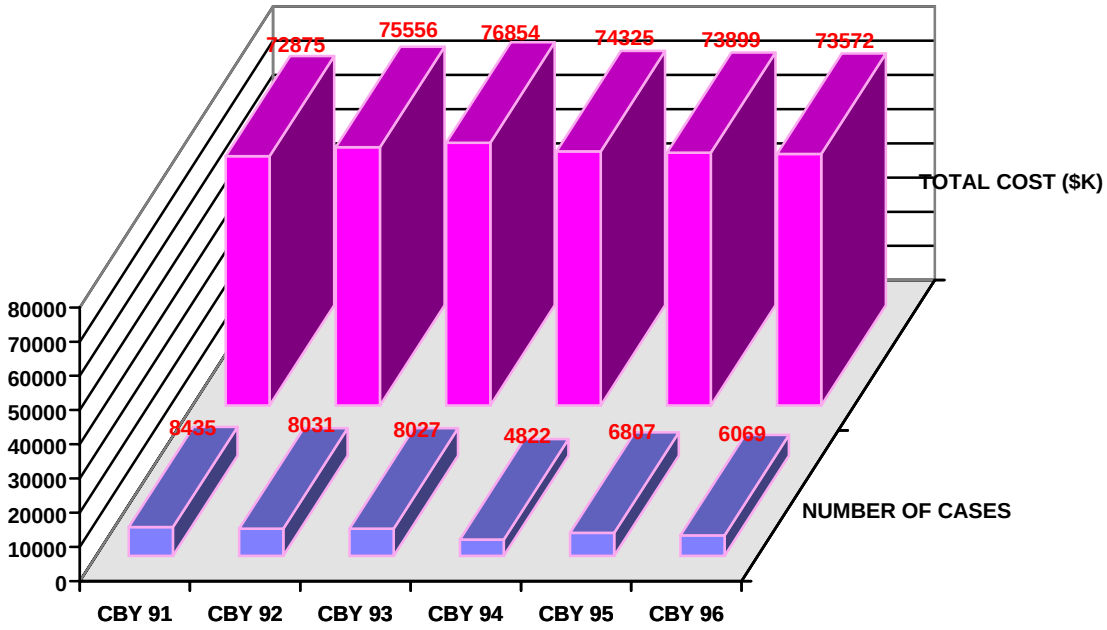


CHART 4

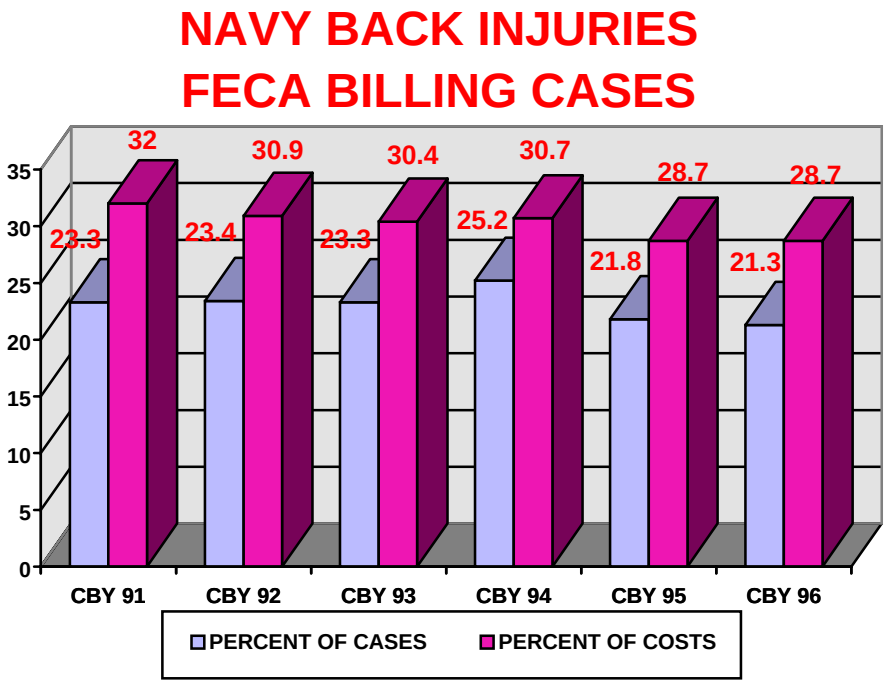


CHART 5

(2) **CONTINUATION OF PAY**. As revealed in Table 2 below, our continuation of pay costs and the number of days off rose slightly above the level of FY 1995, however, they are still substantially below levels before FY 1995. Although the number of cases rose substantially, this rise appears to be due to new accounting methods. As a result of the increase in cases but modest change in the number of days off, the average days off per case, as reported by the Defense Finance and Accounting Center, declined to 0.76 days.

TABLE 2: CONTINUATION OF PAY (COP)

Category	FY 92	FY 93	FY 94	FY 95	FY 96
a. COP Cases	8583	8423	13566	20384	44355
b. COP Cost ($)	7658968	6668430	5336816	4064455	4297270
c. COP Days Off (work days)	90233	66895	51558	33673	33801
d. Avg. COP Days Off	10.51	7.94	3.78	1.65	0.76

Source of Data: DEFENSE FINANCE AND ACCOUNTING CENTER DATA

b. **MISHAP STATISTICS.** The following information concerns lost workday mishaps and occupational fatalities. This information is based on reports submitted by activities to the Naval Safety Center, and varies significantly from FECA reports since it is based only on valid occupational injuries/illnesses that occurred during the fiscal year and resulted in ***five*** or more lost workdays (rather than all FECA cases filed during the year). For reporting and analysis purposes, we use the term lost workday case vice lost time case. A lost workday case is a case where more than 8 hours of work time is lost after the day of injury. We require mishap reports to be submitted to the Naval Safety Center for all cases involving five or more lost workdays. Our fatality database also contains only valid occupational U.S. Naval civilian fatalities that actually occurred during the fiscal year. The information that follows also comes from our Naval Safety Center mishap database.

(1) **OCCUPATIONAL ON-DUTY FATALITIES.** The U.S. Navy experienced two on-duty occupational fatalities in FY 1996 among its U.S. civilian workforce. One occupational fatality occurred when an employee fell 14 feet from a scaffolding to the floor of a dry-dock. A fair-weather that was being positioned for installation on a submarine came loose from a chainfall hook and struck the employee, causing him to fall of the scaffold. The second fatality involved an employee who was removing three underground storage tanks. The employee was crushed between a backhoe bucket and one of the storage tanks when the tank slipped from position on the edge of the excavation.. Charts 6 and 7 below reveal our occupational on-duty fatality experience for the last five years.

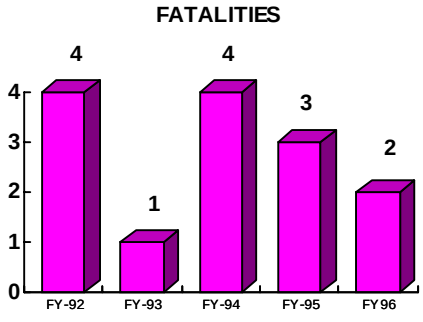


CHART 6

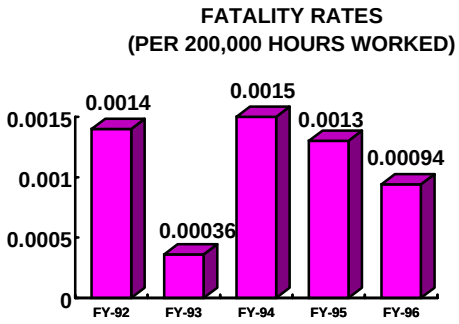
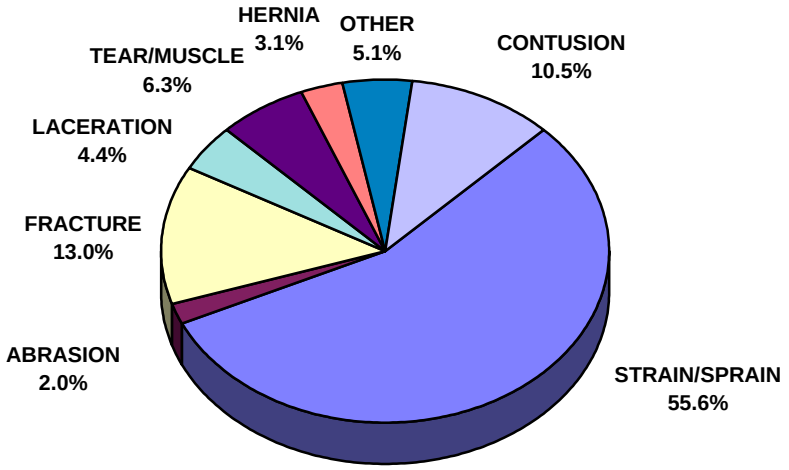


CHART 7

(2) **LOST WORK DAY CASES**. Charts 8 through 11 provide information based on the analysis of data of our serious lost workday mishaps (those involving five or more lost work days). There are no significant trends or changes from past years. The majority of lost work day mishaps continue to result in strains and sprains (55.6 percent), overexertion continues to be the most frequent source of injury (39.5 percent), and backs continue to be the most frequent body part injured (35.5 percent). The most frequent type of activity at time of injury was walking or stepping, accounting for about 26% of the lost workday cases. 25.5 percent of the lost workday cases involved handling materials.

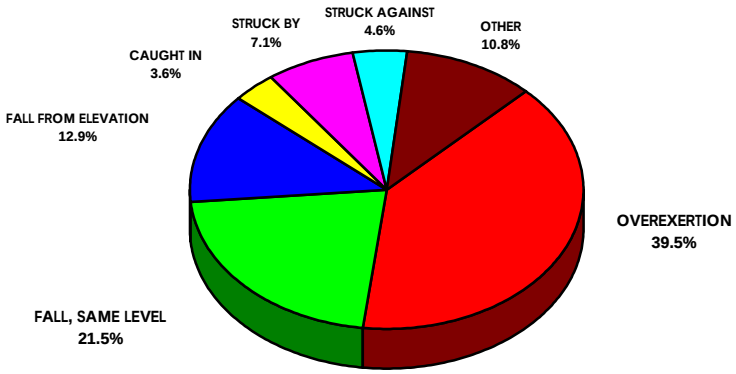
TYPE OF INJURY
FY-96 LOST WORKDAY CASES



Source: NAVSAFECEN

CHART 8

SOURCE OF MISHAP
FY-96 LOST WORKDAY CASES



Source: NAVSAFECEN

CHART 9

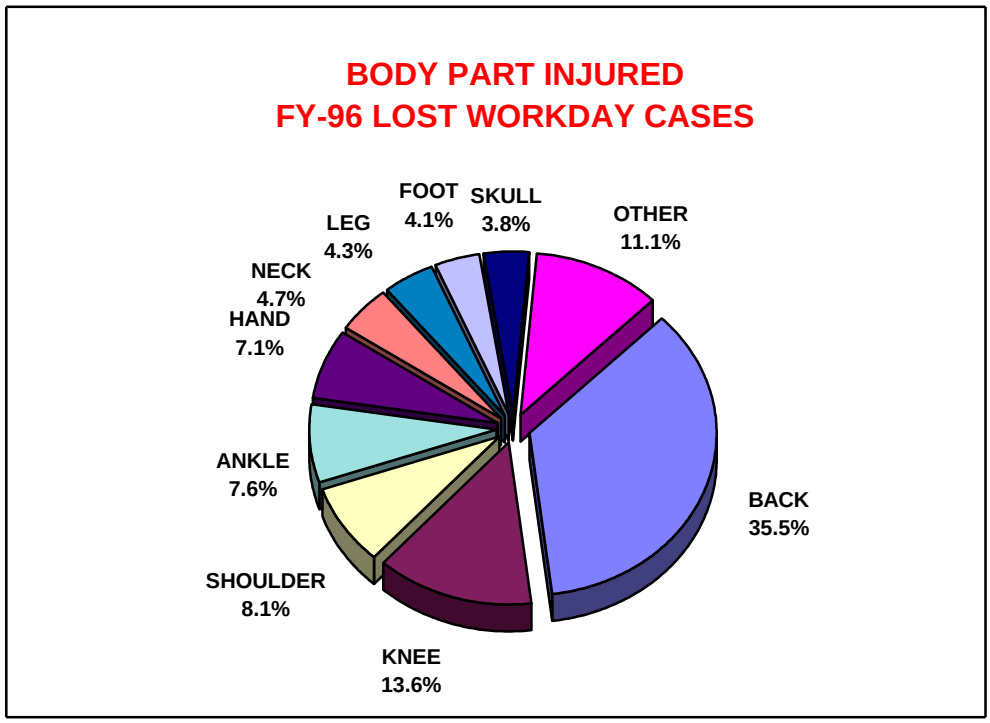


CHART 10

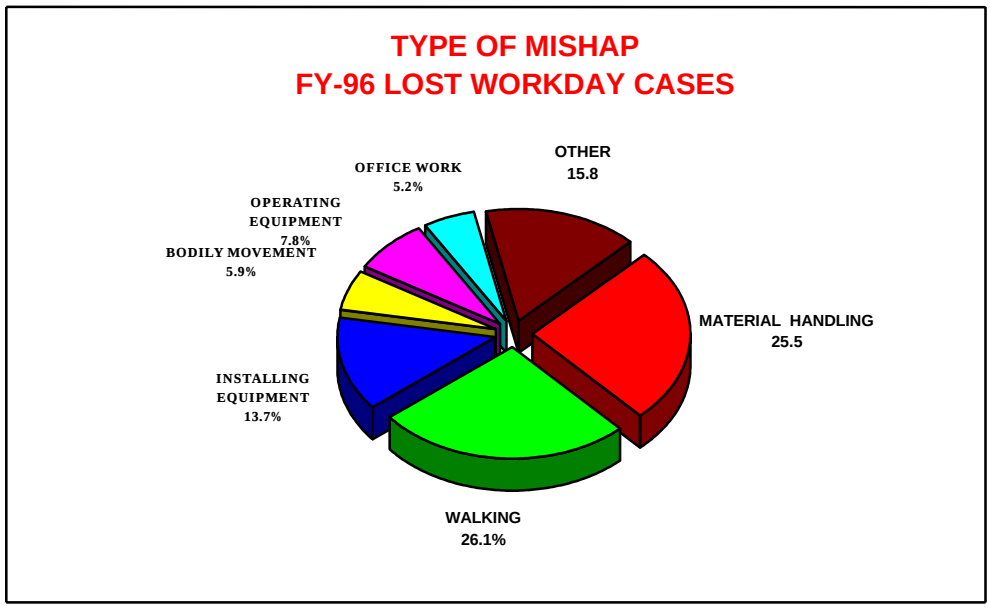


CHART 11

Source: NAVSAFECEN

III. *PROGRAM EVALUATION*

1. THE NAVY INSPECTION PROGRAM. Our three tiered inspection process has been designed not only to ensure compliance with Federal and Navy standards and policies, but also to assess the overall effectiveness of programs and implementation.

- At the first tier, activities are required to maintain local inspection programs that include the inspection of all workplaces at least annually by qualified professionals; the risk assessment of all workplaces to determine if greater frequency of inspection is required; job hazard analyses for hazardous operations; and as warranted by the level of risk, more frequent inspection based on documented schedules. All hazards identified during inspections must be properly recorded and reported, and entered into abatement programs for correction. Activities must also conduct internal reviews of program effectiveness.

- The second tier is at the command level where commands are required to conduct periodic (at least once every three years) OSH program management evaluations of their subordinate activities. These evaluations are structured to review program management and its effectiveness.

- The third tier and our primary monitoring device to measure program effectiveness is the NAVOSH Oversight Inspection Program. This program continues to be the core of our compliance efforts and is managed under the auspices of our Inspector General. Since its inception, over 1560 oversight inspections have been conducted. Table 3 below provides summary information on performance in this program since FY 1983. Chart 12 graphically shows the number of inspections by performance category between FY 1990 and FY 1996.

TABLE 3: NAVINSGEN OSH OVERSIGHT INSPECTIONS

	Satisfactory	Marginal	Unsatisfactory
FY83	**56 (64.3%)**	**13**	**18**
FY84	**70 (76.9%)**	**10**	**11**
FY85	**80 (80.8%)**	**9**	**10**
FY86	**82 (81.2%)**	**15**	**4**
FY87	**87 (82.9%)**	**13**	**5**
FY88	**88 (87.2%)**	**7**	**6**
FY89	**94 (94%)**	**1**	**5**
FY90	**93 (96.9%)**		**3**
FY91	**93 (91.2%)**		**9**
FY92	**98 (95.1%)**		**5**
FY93	**99 (97%)**		**3**
FY94	**96 (97%)**		**3**
FY95	**85 (95.5%)**		**4**
FY96	**62 (98.4%)**	**1**	**0**

SUMMARY
NAVOSH OVERSIGHT INSPECTION RESULTS

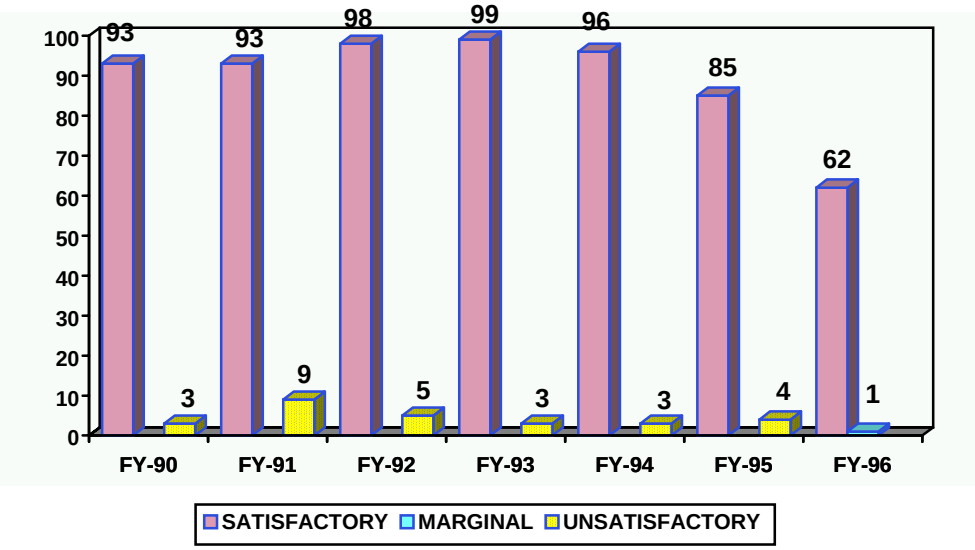


CHART 12

a. During FY 1996, 63 oversight inspections were conducted at our shore activities. These inspections were "unannounced" (less than 30 days notice) and conducted by teams of professional safety and industrial hygiene personnel. We have issued detailed evaluation guides for inspections that outline each program requirement. On each oversight inspection, 30 major program elements are reviewed for compliance. In addition, oversight walkthrough reviews of worksites are made to evaluate program implementation and compliance with standards.

b. Since FY 1989, we have used a quantitative scoring system to rate the compliance status of the NAVOSH program at each activity inspected. Program elements and workplace compliance are weighed equally in scoring, and an overall score of 75 or higher is required for a satisfactory rating. We have now completed seven years of inspections under the quantified scoring system and have good baseline data to measure future inspection trends. As shown on Chart 13 below, the mean score for FY 1996 is 89.

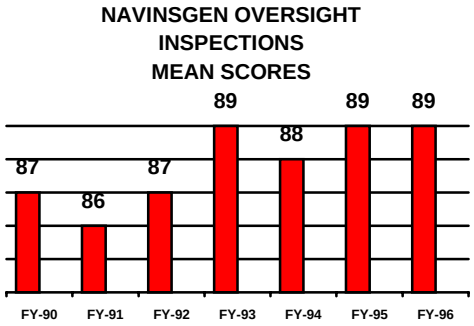


CHART 13

Our satisfactory rating level for FY 1996 was 98.4 percent; the highest ever.

c. We feel our oversight inspection program is without peer and serves as a driving force in our efforts to provide safe and healthful workplaces for all Navy personnel. We continually try to improve and enhance this program. Formal reports are issued by the Inspector General for each inspection, and submitted to the Secretary of the Navy and Chief of Naval Operations. Attention and concern are high at all levels of command for this program.

d. As you can see in Charts 12 and 13, compliance and performance have remained relatively consistent since FY 1990. A review of the findings of these inspections reveals the most frequently observed program deficiencies were occupational reproductive hazards (a new program element for review), training, command support, hazardous material control and management, hazard abatement, hearing conservation, and industrial hygiene surveys. Table 4 below provides information on administrative program deficiencies cited during inspections. As shown in Table 4, hearing conservation and industrial hygiene surveys appeared as a significant program deficiency for the first time in FY 1996. Training deficiencies are analyzed in Chart 14. Workplace deficiencies cited during inspections during FY 1996 in rank order were electrical safety, machine guarding, hazardous material control and management, weight handling, respiratory protection, and walking/working surfaces.

TABLE 4
MOST FREQUENT PROGRAM DEFICIENCIES*
FY-91 THROUGH FY-96

Deficiency	**FY91**	**FY92**	**FY93**	**FY94**	**FY95**	**FY96**
REPRODUCTIVE HAZARDS**						70%
OSH TRAINING	60%	65%	59%	63%	56%	66%
HMC&M	43%	55%	48%	59%	51%	64%
COMMAND SUPPORT***			41%	46%	40%	64%
HEARING CONSERVATION	33%	26%	34%	36%	39%	57%
INDUSTRIAL HYGIENE SURVEYS	41%	33%	31%	38%	37%	51%
MISHAP INVESTIGATION	52%	53%	23%	39%	37%	49%

NOTES: * Percent of inspections with a finding in the listed program element.
** Appears as significant deficiency for first time in FY 1996.
*** Command support was not reviewed as specific program element until FY 1993.

e. Chart 15 on the next page, shows the trends over the past few years in workplace deficiencies. There do not appear to be significant trends, with weight handling appearing for the last two years due to special emphasis.

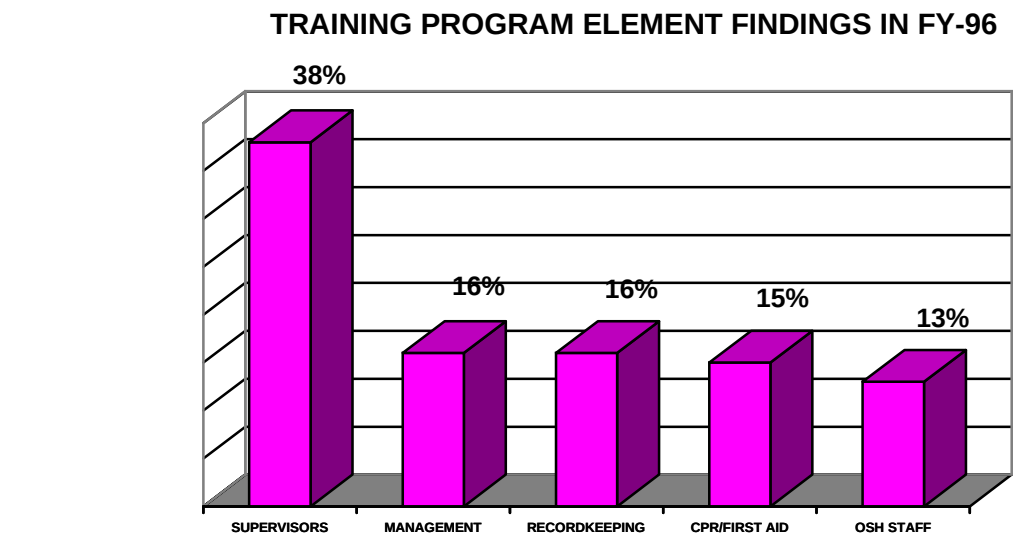


CHART 14

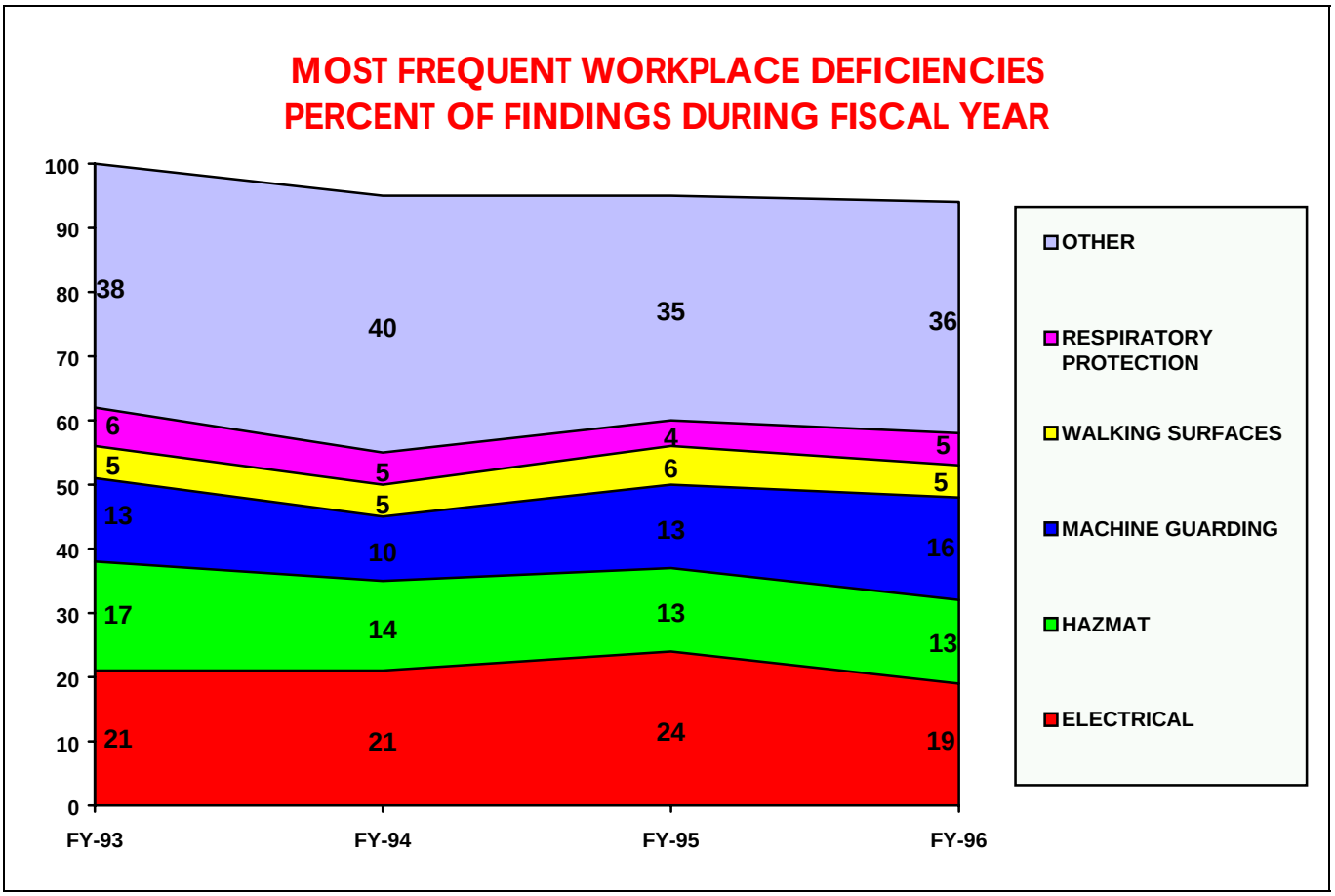


CHART 15

IV. SIGNIFICANT OSH ACCOMPLISHMENTS AND INITIATIVES.

Our programs and initiatives have been directed to reducing our occupational injury and illness claims, our overall mishap experience, and improving the working environment for our employees. Our interest is in both controlling costs and improving employee well-being. We have used detailed analyses of our mishap, claims and inspection experience to target program initiatives. The following discussion outlines major programs and initiatives last year.

1. THE NAVOSH STRATEGIC PLAN. Since 1993 we have undertaken a major initiative to develop and implement a strategic plan for the NAVOSH program. As part of the strategic planning process, the NAVOSH Quality Council was established with membership representing safety and occupational health professionals throughout the U.S. Navy. The Council developed the NAVOSH Strategic Plan (December 1993/revised October 1994 and November 1996) that contains our mission, long term vision, guiding principles and strategies for NAVOSH, and the Council has been overseeing the plan's implementation. A copy of the current plan is attached.

a. The plan encompasses five major strategies on communications and information systems, process review and measurement; planning, engineering and acquisition; training and education; and occupational health support. For each strategy, specific goals and objectives have been developed and a timetable for goal accomplishment is established.

b. For each strategy, a quality management board (QMB) has been established with supporting process action teams, where appropriate, to facilitate development and implementation of the strategies and goals.

c. The NAVOSH Strategic Plan provides our program goals and objectives for the next five years. During FY 1996, the QMB's and NAVOSH Quality Council met regularly working on implementation of strategic plan goals and objectives. The following is a summary of significant accomplishments under the plan during the year:

(1) A major strategy in the NAVOSH Strategic Plan concerns communications and information systems. We have a multi-year plan to determine our needs, identify systems, and provide a comprehensive and coordinated NAVOSH information system. Under the QMB for Communications and Information Systems, a PAT has been established for Occupational Health automation. A main initiative during FY 1996 was the PAT's development of a standard automated program for industrial hygiene.

(2) Our Planning, Engineering and Acquisition QMB developed a plan for an automated system to incorporate safety and health into the facility design process. This project in nearing completion of development and will provide standards, criteria, references and points of contact to planners and designers. Using the concept developed for facilities, the QMB is now working on a process for ships and weapons system design.

(3) Process Review and Measurement. This QMB has been pursuing two major initiatives in implementation of strategic plan objectives. The first initiative is to develop a

performance measurement system for shore activities. Considerable progress has been made in this effort and a measurement model is being evaluated. The second major initiative is a zero based review of NAVOSH regulations. The purpose of this review is to simplify requirements, remove redundancies, and remove unnecessary/non-value added requirements in the spirit of reinvention and downsizing. The QMB's review was completed during the year and the changes approved by the quality council will be incorporated during FY 1997.

(4) Training. The NAVOSH Training Steering Committee acts as the Strategic Plan QMB for training. As discussed later in this report, continuing improvements are being made in training and training programs for all of our personnel ashore and afloat.

d. In the area of occupational health, a new QMB for occupational health support was created by the Quality Council with four main goals: review/redefine roles and responsibilities, validate/reestablish requirements and priorities, standardize processes, and develop a performance measurement system. During the year, the QMB made considerable progress in meeting goal objectives including developing a customer and provider survey, identifying key processes for standardization, and identifying key elements in occupational health support for measurement. Considerable work has been completed on industrial hygiene and occupational medicine measures.

2. <u>MISHAP REDUCTION INITIATIVES</u>. We continued to incorporate quality management concepts into our efforts to attain overall OSH program improvement. In addition to our initiatives under the NAVOSH Strategic Plan as discussed above, our principle reduction initiative with commands and activities is to get them to develop program improvement plans tied to mishap reduction. Our concept, as explained in past years, is called OSHPIP (Occupational Safety and Health Program Improvement Plans). Under the concept, each command identifies its program deficiencies and mishap trends, and develops strategies and actions to improve the programs and processes. In FY 1996, we completed our seventh year of this program. Through OSH quality management boards and process action teams, our industrial commands have made significant achievements in hazard control. The following summarizes many of our initiatives aimed at **reducing mishaps and injury compensation claims experience and associated costs:**

a. We have continued to develop and provide quarterly performance reports tied to overall reduction goals with performance charts and guidance for goal attainment. We have continued to monitor performance each quarter, and have provided revised performance charts to major commands. In addition, we provided three courses in statistical process control for safety, to teach and provide tools to activities for injury/illness data analysis.

b. Continuing our improvement efforts in mishap investigation as discussed the last three years, we have provided improved training, established a PAT to review reporting requirements and reporting forms, and continued to use the CNO Mishap Review Board to periodically review significant occupational mishaps. The Board met in 1996 to review significant mishaps involving fatalities and/or major property damage, and to track the status of action to implement mishap prevention recommendations. The Commanding Officer or Executive Officer for the

affected activity makes a presentation to the Board on each mishap reviewed. The Board has been very effective in giving greater attention to systemic improvements and preventive measures as identified in mishap investigations.

c. **CRANE SAFETY.** In 1996, we continued our emphasis and initiatives to improve crane and weight handling safety throughout the Naval shore establishment. A substantially revised manual on weight handling program management was issued increasing and improving in safety guidelines and requirements. Continuing to use the Naval Inspector General Report on Crane Safety, meetings were held to review recommendations and implementation actions. 31 of the 35 recommendations of the Inspector General had been completely implemented by the end of the year. Improvements included mishap tracking, publication of lessons learned, training, rigging standards, program promotion, testing and inspection, work practice guides, and oversight.

d. **ERGONOMICS.** Our initial ergonomics standard was issued in 1989 and was revised in 1994. In implementation of these program requirements, many actions have been taken by commands and especially our industrial activities to develop ergonomics programs. These efforts have been very successful, especially through the use of TQM concepts and worker involvement. In fact, our most successful programs have been driven by a cooperative effort between management and workers that encourages workers to identify and develop ergonomic solutions to workplace stressors. In recognition of this, we completed a Navy Corporate Ergonomics Plan in FY 1995, and following the plan, selected several target installations (model sites) for pilot implementation. The plan provides a comprehensive strategy for implementing an ergonomics process in the worksite over a two year period. Our emphasis in the plan is providing training of managers, ergonomics coordinators, and worker ergonomics teams. Through the teams, an ergonomic process will be implemented at the targeted activities. The process and plan recognizes the importance of management support, worker involvement, and strong oversight/facilitation. The plan also includes measures of effectiveness and data collection requirements. Experts are sent to the model sites to aid in implementing and monitoring the process. Six model sites and two ships are included in the pilot program. They have been visited by our Ergonomics Team, on-site training has been conducted, local teams established, and ergonomic processes initiated. Upon completion of this pilot program, the process will be expanded to other sites throughout the Navy. As part of our efforts, we have also established “Ergo News” as a program/process promotional tool for our activities.

e. **MISHAP COST REDUCTION.** We continued our major effort to develop an automated program for mishap cost-reduction analysis. The program development was transferred to professional actuaries, and will provide a standardized process for activity performance analysis and comparison. We believe this effort has application throughout the Federal government and will provide very useful tools for OSH program analysis. The program provides not only standard analytical screens, but also contains equations for "normalizing" data that will permit better comparisons between different types of activities or organizations. We will continue the development of this program for use throughout the U.S. Navy and, hopefully, for evaluation by the Department of Labor and the entire government.

3. THE NAVOSH TRAINING PROGRAM. We continued to expand NAVOSH training in FY 1996 with many new courses offered and additional course offerings provided. Our emphasis continues to be to provide professional training at the sites (bases) where the highest demand exists. Our FY 1996 schedule included over 33 formal classroom courses, with almost 350 class offerings, and trained approximately 7,700 students. Subjects ranged from advanced mishap investigation to construction safety. We believe we offer the most comprehensive safety professional training program within the U.S. government.

a. We continue to oversee the training process through the NAVOSH Training Steering Committee that acts as the quality management board (QMB) for safety and occupational health training. It is established through the Naval Training Plan (NTP) as a means of providing broad command input in the training process. The Steering Committee is supported by four working groups (acting as process action teams (PATs)) representing the four communities in the Navy (air, ships, submarines and shore). Through these groups, requirements are identified, defined and incorporated into the NTP for development and implementation. Numerous changes were made to the NTP action plan during the year based on reviews and recommendations made by the working groups. The steering committee was also made the QMB for the NAVOSH Strategic Plan strategy for training, which is discussed earlier in this report.

b. We continued our emphasis on significantly improving training, especially afloat, with continued course review, and development of standard videotapes for distribution to both fleet and shore commands. The pilot tuition reimbursement program, started in FY 1994, was refined and expanded during the year with additional training options added. Other training improvement initiatives included revised training catalogs, lesson plan guides, course audits and reviews, and technical curriculum reviews.

c. Finally, we conducted a very successful NAVOSH Professional Development Conference with approximately 300 personnel in attendance. The five day conference included lectures on levels of change; regionalization, reorganization, and outsourcing; contractor oversight; ethics and professional conduct; coping with change; new directions in hazardous material management; NAVOSH Update; and change through mishap investigation. In addition, several seminars were provided on TQM and safety, stress management, confined space safety, mishap investigation, creative thinking, ergonomics, weight handling safety, briefing techniques, compensation case management, and current medical issues.

4. WORKPLACE HAZARD ABATEMENT: THE NAVOSH DEFICIENCY ABATEMENT PROGRAM. An integral part of our mishap prevention program is the correction of workplace hazards identified during inspections, investigations, evaluations, oversight inspections, and as a result of employee hazard reports. Our program to correct hazards and improve the workplace is explained in the NAVOSH Program Manual (OPNAVINST 5100.23D, Chapter 12). The Naval Facilities Engineering Command (NAVFAC) has lead responsibility for administering our centrally managed program to abate major deficiencies.

a. An effort begun in FY 1995 to discover innovative ways of executing facilities projects in a timely manner was continued in FY 1996. The intent of this effort is to correct hazards to Navy employees as rapidly as possible. To meet this objective, the use of "in-house" public works staff was continued and additionally, there was added use of "base operating support" and job order contracts for project execution. These actions have resulted in faster turnaround and, thus quicker abatement of hazards. Continued emphasis has also been placed on correcting the most hazardous projects first, vice the oldest projects.

b. Expenditures in FY 1996 under the centrally funded NAVOSH Deficiency Abatement Program were $8.7 million for approximately 56 projects, including individual facilities projects, and several program improvement studies or projects. From 1979 to 1996, over $291 million has been expended under our centrally managed program to correct serious workplace deficiencies, and over 1587 major facility projects have been completed. Projects funded include asbestos removal, industrial ventilation improvements, life safety hazard abatement, electrical safety hazard removal, hazardous material control and storage, and fall protection.

c. Outyear target projections for the NAVOSH Deficiency Abatement Program are as follows:

FY 97	$13.4 million
FY 98	$11.8 million
FY 99	$10.8 million
FY 00	$11.2 million
FY 01	$11.1 million

Program focus in FY 1997 will be to continue to improve service to shore activities in executing local deficiency abatement projects; to streamline the process for acquiring and distributing funds; to continue to assure the most hazardous deficiencies are corrected first; and to identify the most cost effective and rapid methods for executing projects. To achieve these ends, several pilot initiatives have been instituted which will be continued and expanded if they prove to be successful.

- Management of East coast projects has been consolidated at one focal point from which funds will be distributed directly to the most efficient executing agency.

- Design of fall protection and fire protection/life safety projects has been consolidated at one location to assure optimum design development and to preclude duplication of effort.

- A project presentation round table has been established to allow activities to more clearly present their most hazardous projects to a panel of experts for approval . The round tables will be held on a regional basis as needed during in the future.

- We will continue to offer our course to train local asbestos program coordinators in asbestos management practices.

5. REGIONALIZATION AND DOWNSIZING. The impact of downsizing and funding reductions has resulted in numerous initiatives to reduce infrastructure through regionalization, consolidation, and outsourcing. In order to assure effective safety and occupational health programs are maintained in this difficult environment, NAVOSH staff have taken an active role as consultants in these efforts. This has included membership on boards, committees, QMBs and teams working on the initiatives. Efforts are underway to establish consolidated or regionalized offices at major naval fleet concentration locations. We are working to assure the regional or consolidated offices are adequately staffed and structured to meet mission as well as regulatory requirements.

6. NAVOSH AFLOAT. Significant initiatives in the afloat occupational safety and health program not covered elsewhere in this report are as follows:

a. During FY 1996, a revision to the NAVOSH Afloat Manual was issued. This manual provides guidance to shipboard personnel on the establishment and management of safety and occupational health programs aboardship, and additionally provides shipboard hazard control standards.

b. As discussed in Section 3. above, increased emphasis was placed on NAVOSH training ashore and afloat. Ten shipboard specific courses are offered by the NAVOSH and Environmental Training Center covering such topics as hazardous material, safety programs afloat, aviation safety, and asbestos emergency response. Due to the high demand, approximately 110 afloat related classes were offered during the year. Revisions to the NAVOSH and HMC&M Navy Training Plan were made to clarify and strengthen afloat training and assure military orientation, apprentice and journeyman training include appropriate safety and occupational health information. Development continued on afloat safety training videotapes.

V. SAFETY BELT USE PROGRAM.

1. The Navy's policy on safety belt use is contained in OPNAVINST 5100.12F. The Navy requirements include:

a. All persons operating or riding in a government motor vehicle are required to wear a safety belt at all times.

b. All Navy military personnel are also required to wear safety belts in their personal vehicles or while riding in any private motor vehicle both on and off Navy property.

c. Navy federal civilian employees are required to wear safety belts in private vehicles off a Navy property while in a duty status. Everyone is required to wear safety belts while on a Navy property (civilian guest, contractors, dependents, etc.). Violation of the Navy's safety belt use regulation is punishable under the Uniform Code of military Justice for Military personnel, and is the basis for administrative disciplinary action for civilian employees.

2. Actual observances of safety belt use are periodically conducted at many Navy activities. However, there is no requirement for the results of these surveys to be centrally reported. During visits to activities by Naval Safety Center staff, seat belt surveys are conducted. These surveys are made during weekdays and include all vehicles at a particular location at the activity. Observed usage rates range from 73 to 92 percent.

3. Occupant protection programs and activities conducted in FY 1996 include the following:

a. Eight messages were released on all aspects of traffic safety including alcohol countermeasures, occupant protection, pedestrian safety, travel precautions, risk assessment and risk management.

b. Eight motorcycle safety training courses were conducted and 63 instructors trained. Nine AAA-DIP instructor courses were conducted with 76 instructors being trained. Thirteen EVOC courses were conducted resulting in 217 trained personnel. Nine traffic safety surveys were conducted.

c. 4500 National Highway Traffic Safety Administration Safe and Sober Quarterly Planners and 300 Drunk and Drugged Driving Awareness Monthly Planners were distributed to Navy and Marine Corps activities world-wide.

d. Traffic safety risk assessment and risk management is taught in Navy traffic safety courses.

4. A summary of injuries and seat belt usage data for on-duty motor vehicle accidents during FY 1996 is presented in Table 5 on the next page.

TABLE 5: U.S. NAVY SAFETY BELT USE
FY-96 ON THE JOB MOTOR VEHICLE ACCIDENT'S GMV/PMV

Navy Civil Service

Belts Worn	Not Worn	Unknown
Cost $2,341,987 *	Cost $1,404,251*	Cost $124.220 *
Deaths 2	Deaths 2	Deaths 0
Injuries 23	Injuries 1	Injuries 3
LWD 490	LWD 13	LWD 44
No Injury 36	No Injury 5	No Injury 4

Navy Military

Belts Worn	Not Worn	Unknown
Cost $1.365,234 *	Cost $164,774 *	Cost $38,350 *
Deaths 2	Deaths 0	Deaths 0
Injuries 13	Injuries 6	Injuries 1
LWD 277	LWD 206	LWD 6
No Injury 163	No Injury 4	No Injury 8

*** Cost includes injury/death cost plus any reportable property damage. The information above includes only those mishaps with property damage in excess of $2000 and/or injuries with five or more lost work days as reported to the Naval Safety Center.**